HAWAII PRESCRIPTION CARE ASSOCIATION

P.O. Box 25370
Honolulu, HI 96825
Phone: 599-6000; 1(800) 599-6441

What Do We Do?

We work with needy individuals and over 100 pharmaceutical companies to provide access to prescription drugs to such individuals. These pharmaceutical companies give many of the drugs they make at no charge (or a nominal feed of $5 or $10 per prescription) to individuals who are below a certain income level. The application and income level is different for each company. These pharmaceutical companies require proof of the individual's income be attached to all applications. We are a non-profit organization that gathers the required information from the individual and his or her doctor, completes the application and sends them to the pharmaceutical companies for approval.

The individual must agree to share his or her private health and financial information with the pharmaceutical companies to obtain their free medications. Please review the Description of Privacy Protection for Health Information and the Notice of Privacy Protection for Personal Financial Information for our policies regarding the treatment of an individual's personal health and financial information.

What Happens Next?

If the pharmaceutical company approves the individual, in most cases it send a three-month supply of drugs directly to his or her doctor's office. The individual picks up the medicine at the doctor's office.

How Long Will It Take Before I Receive Medicines?

From the time we receive all of the individual's paperwork, it will typically take 4-6 weeks before he or she receives medicines. After applications are completed and sent to the pharmaceutical companies, it usually takes the pharmaceutical companies approximately 4 weeks to review the applications and mail the medicines to the doctor's office.

After An Individual Receives His/Her Drugs, How Does He/She Get A Second Supply?

When an individual picks up a medicine from his/her doctor's office it is very important that he/she call Hawaii Prescription Care at 599-6000 or on neighboring islands at 1-(800) 599-6441, and report the name of the medicine, the date it was received and how many months of supply was received. Every three months a new application must be sent to the pharmaceutical company in order for the individual to receive another three-month supply of medicines. We will automatically complete applications every three months if the individual has called and reported that he or she has received medicines. If an individual does not call us at 599-6000 or 1 (800) 599-6441 we will not know when to redo the application and the individual will not receive more drugs.

Please call Hawaii Prescription Care Each Time You Receive Medicine Under Our Program

HAWAII PRESCRIPTION CARE

How Do I Enroll In the Program?

You must first call us to see if you may be eligible for the program at 599-6000 or 1 (800) 599-6441. A referral packet containing several forms for you to complete and one form for your doctor to complete will be mailed to you. You must complete:

1. Page 1-4 of the referral form (every blank must be completed)
2. Page 5 Individual Authorization/Consent for Use and Disclosure of Information Form
3. Page 6 Individual Signature Authorization
4. 4506 Request for Copy or Transcript of Tax Form (complete 1-5 and check b under #8 and sign the form where indicated). This form is verification that you did not file an income tax return. It is required by several of the pharmaceutical companies. If you did file an income tax return, please do not complete this form.

You must also include copies of proof of income. If you are married, you must also send copies of your spouse's income. Proof of income may be one of the following:

1. If you file income tax, a copy of your most recent tax return.
2. If you do not file income tax, a copy of your Social Security Award letter for 2003 and or pension statements.
3. If you do not have your awards letter, you may send a copy of your most recent bank statement showing direct deposits of your social security check or pension income.
4. If you are working and your income is from wages earned, you must send copies of your pay stubs from the last three months.

The pharmaceutical companies require thee specific documents as current poof of income. We must attach copies of your income to the applications we send to the pharmaceutical companies. Without complete proof of income we cannot process your applications.

Take your completed pages 1-6, Form 4506, copies of your proof of income and page 6 with the list of medicines attached, to your doctor's office. Your doctor's office must complete page 7.

Ask your doctor's office to complete page 7 and fax or mail all of the information to us TOGETHER. Fax# (808) 599-6003.

HAWAII PRESCRIPTION CARE
NOTICE OF PRIVACY POLICY
FOR PERSONAL FINANCIAL INFORMATION

Your personal financial information, such as income, living expenses, and personal information concerning your financial circumstances will be provided to pharmaceutical companies, government agencies, and other agencies or organizations that provide health care, health insurance, or financial assistance with your specific authorization.

We may also use aggregated case file information for the purpose of evaluating our services, improving our program, and designing future programs. Your anonymity will be maintained through the use of your client number or by using aggregate data in all circumstances.

In all other situations, your personal financial information may be released to appropriate individuals or agencies only upon your written request or when our staff has been served a valid subpoena.

The following PRIVACY PRACTICES detail circumstances under which we will release your personal financial information to a third party:

We do not disclose, nor do we wish the right to disclose, any nonpublic personal financial information, about our clients or former clients to anyone, except as is described in the following paragraph or as permitted by law. We may compile data and aggregate information that you give to us, but this information may not be disclosed in a manner that would personally identify you in any way.

We may disclose some or all of the personal financial information that we collect, as described below, to pharmaceutical companies, government agencies, and other agencies or organizations that provide health care, health insurance, or financial assistance who need this information in order to provide such assistance.

We restrict access to nonpublic personal financial information about you to those employees who need to know that information to provide services to you. We maintain physical, electronic, and procedural safeguards to guard your nonpublic personal financial information.

We collect nonpublic personal financial information about you from the following sources:

- Information we receive from you on your applications or other forms you provide; and
- Information we receive from others.

We may disclose the following kinds of nonpublic personal financial information about you:

- Information we receive from you on applications or other forms, such as your name, address, social security number, assets and income;
- Information about your transactions with us; and
- Information we receive from others.

HAWAII PRESCRIPTION CARE
DESCRIPTION OF PRIVACY PRACTICES FOR HEALTH INFORMATION

This description provides information about how health information about you may be used and disclosed by Hawaii Prescription Care Association, a Hawaii nonprofit corporation doing business as Hawaii Prescription Care. Please review it carefully.

Hawaii Prescription Care is not a health care provider, a health plan, or a clearinghouse and, therefore, is not subject to federal and state health care privacy laws. Although Hawaii Prescription Care endeavors to treat data collected about you as privately and confidentially as reasonably possible, numerous uses and disclosures of such information are necessary or helpful to provide services to you and for operational purposes of Hawaii Prescription Care.

To assist you in obtaining prescription medications that you are not able to afford, Hawaii Prescription Care obtains health information from you, your health care providers, and other sources. Generally, we will obtain your authorization so Hawaii Prescription Care can receive health information from your health care providers and, possibly from other sources. You also will be asked to sign an authorization allowing Hawaii Prescription Care to sign documents on your behalf.

You may refuse to sign these authorizations. If you do not sign these authorizations, then you are responsible for providing Hawaii Prescription Care the information needed or useful for completing applications, requests, and other documents, which likely will slow down the process.

You are not required to give Hawaii Prescription Care your confidential financial and medical information; however, Hawaii Prescription Care will not be able to assist you without this information.

To provide services to you, Hawaii Prescription Care must disclose your health information (as well as your financial information) to pharmaceutical companies, government agencies, and other agencies or organizations that provide health care, health insurance, or financial assistance. After this information is shared with the pharmaceutical companies and other agencies and organizations, your information may not be treated confidentially.

If you have any questions or concerns, please contact Hawaii Prescription Care at 808-599-6000.

HAWAII PRESCRIPTION CARE

Physician/Prescriber Instructions for submitting the Medication Information form:

The physician/prescriber must complete page 7, which is the Medication Information. A formulary of medications is attached for your convenience. Only brand name drugs can be obtained from the individual assistance programs.

The individual must complete pages 1-6 of the request form and the 4506 tax form (if they do not file income tax). He/She must provide proof of his/her income and that of his/her spouse (if applicable). Acceptable documents that may be used as proof of income are described in the individual's instructions.

You may fax all information to us at 599-6003 or you or your patient can mail the information to us at:

When faxing or mailing information, please be sure to include:

1. Pages 1-7 of the request form
2. Tax form 4506
3. Complete proof of income

Requests with missing information cannot be processed. Mahalo.

PRINT OR
TYPE ONLY

Individual Questionnaire
For Individual Only

Phone: 599-6000, 1-800-599-6441 Fax: 599-6003

What is your…

Last name? _____

First name? _____

Middle name? _____

Phone number? _____

Street address? _____

Apartment number? _____

City? _____

State? _____

Zip code? _____

Hawaii County? _____

E-mail address? _____

Date of birth? _____

Social Security Number? _____

Primary language spoken?

□ English □ Japanese □ Filipino Other _____

Gender? □ Female □ Male

Race? □ African American □ Hawaiian □ Chinese □ Japanese

□ Puerto Rican □ Tongan □ Taiwan □ Filipino

□ Guamian/Chamorro

□ American Indian □ Samoan □ Korean □ Vietnamese

□ Mexican □ Caucasian □ Asian Indian

□ Portuguese □ Other Asian _____

□ Other _____

Marital Status? □ Single □ Married □ Widowed □ Separated □ Divorced

Individual Questionnaire
For Individual's Only

How many people live in your household? _____

How many people do you claim as dependents on your Tax Returns? _____

Does anyone claim you on his/her Tax Returns? _____

Who is your primary care provider or family doctor? _____

What is the name of his/her private practice/clinic/hospital? _____

What is his/her phone number? _____

How did you hear about Hawaii Prescription Care? _____

Are you a US Citizen or legal resident? □ Yes □ No

Individual Questionnaire

Do you receive money from any of the following? If yes, please indicate how much you receive each month. If you receive income from a source not listed below, please specify the source under "Other."

Supplemental Social Security	□ No	□ Yes	Monthly Amount	$_____
Disability	□ No	□ Yes	Monthly Amount	$_____
Pension	□ No	□ Yes	Monthly Amount	$_____
Unemployment	□ No	□ Yes	Monthly Amount	$_____
Social Security	□ No	□ Yes	Monthly Amount	$_____
Alimony or Child Support	□ No	□ Yes	Monthly Amount	$_____
Salary or wages	□ No	□ Yes	Monthly Amount	$_____
Other: _____	□ No	□ Yes	Monthly Amount	$_____
_____	□ No	□ Yes	Monthly Amount	$_____

Please indicate if you have any of the following medical expenses. If you do, please indicate how much you pay each month. If you have other medical expenses, please specify them under "Other."

Prescription Medications	□ No	□ Yes	Monthly Amount	$_____
Lab Fees	□ No	□ Yes	Monthly Amount	$_____
Office Visits	□ No	□ Yes	Monthly Amount	$_____
Other: _____	□ No	□ Yes	Monthly Amount	$_____
_____	□ No	□ Yes	Monthly Amount	$_____

Do you have any of the following assets? If yes, please indicate their current value. If you have any assets not listed below please specify them under "Other."

Stocks and/or Bonds	□ No	□ Yes	Current Value	$_____
Certificates of Deposit (CDs)	□ No	□ Yes	Current Value	$_____
Checking Account	□ No	□ Yes	Current Value	$_____
Savings Account	□ No	□ Yes	Current Value	$_____
Individual Retirement Accounts (IRAs)	□ No	□ Yes	Current Value	$_____
Annuities	□ No	□ Yes	Current Value	$_____
Other: _____	□ No	□ Yes	Monthly Amount	$_____
_____	□ No	□ Yes	Monthly Amount	$_____

Individual Questionnaire

Please complete the following information about your health insurance.

Primary Insurance Policy _____ Policy Number _____

Secondary Insurance Policy _____ Policy Number _____

Do you have insurance that covers Prescriptions? □ Yes □ No

If yes, how much is covered per year? $_____
Have you reached this limit? □ Yes □ No If yes, when? _____
When will you have coverage again? _____

Do you have Medicare Coverage? □ Yes □ No Medicare Number_____

Do you have Medicaid Coverage? □ Yes □ No

Do you have Veterans Assistance? □ Yes □ No

Do you use any pharmaceutical company discount cards? □Yes □ No
If yes, which one(s)? _____

As far as you know, are you allergic to any medications? □ Yes □ No
If yes, which one(s)? _____

When was your last…

Office Visit? Date _____ Reason _____

Stay in hospital? Date _____ Reason _____

Emergency room visit? Date _____ Reason _____

Optional: Please complete the following information if there is an alternative contact (family member, social worker, etc.) that we should communicate with.

Last name: _____

First name: _____

Street Address: _____

Suite/Apartment Number:_____

Phone Number: _____

City: _____

State: _____

Zip Code: _____

Relationship to Individual _____

Should this be our primary contact? □ Yes □ No
If yes, please indicate why: _____

Personal information received will be treated with confidentiality and viewed only by Hawaii Prescription Care personnel. The individual may inspect information we have on file at any time and request that changes be made.

Hawaii Prescription Care Association dba Hawaii Prescription Care
AUTHORIZATION/CONSENT FOR USE & DISCLOSURE OF INFORMATION

Individual Name _____ Date of Birth _____

Individual Address _____

Individual Telephone _____ Social Security # _____

I authorize/consent to the use/disclosure of health information about the above named individual as follows:

1. I give permission to my health care provider or prescriber of medication to disclose the information described below to authorize representatives of Hawaii Prescription Care Association, doing business as Hawaii Prescription Care and for Hawaii Prescription Care to use and disclose such information for the purposes of described below.

2. The health information that may be used/disclosed/received includes general, demographic, and health information about the Individual, including individually identifiable individual information in any form or medium, including a copy of the Individual's medical records, discussions of the Individual when requested.

I specify authorize/consent to the use, disclosure, or receipt of the information listed below:			
□ Mental health information	□ Substance abuse information	□ Developmental disabilities information	□ AIDS, HIV, ARC
Specify period of time during which the information is to be released*: _____ Include dates during which this consent is operable*: _____ * These two sections are mandatory to disclose mental health information.			

3. I further give permission to authorized representatives Hawaii Prescription Care to verify my income through the Department of Social Services, Social Security Administration, my employer, Veteran's Administration, or any other company, business, or organization from which I receive income.

4. The information will be used/disclosed/received to solicit medications on behalf of the Individual or obtain medications or payment for medications through individual assistance programs.

5. The above-described information may be subject to redisclosure and no longer protected by federal regulations.

6. This authorization is not a condition of treatment, payment, enrollment, or eligibility for benefits. If I do not sign this form, information will not be shared, and I will have to contact each agency or organization individually to give or receive the information about me that it needs.

7. I may revoke this consent form in writing at any time by notifying Hawaii Prescription Care, except to the extent that action has been taking in reliance on this authorization.

8. Unless earlier revoked, this authorization is binding for a period of one year from the date of this authorization and for as long as Hawaii Prescription Care assists the Individual.

9. I agree that a copy of this form can be accepted as a valid authorization to use, disclose, or receive information.

10. I may inspect or copy any information used/disclosed under this authorization. I received a copy of this authorization.

SIGNATURE: I have read this authorization form, and I understand it:

_____ _____
Signature of Individual or Personal Representative Date

_____
Please print name of Personal Representative (if applicable)

If not signed by Individual, description of authority: _____

PRINT OR
TYPE ONLY

Physician/Prescriber Referral for Medications
Individual Only

Phone: 599-6000, 1-800-599-6441 Fax: 599-6003

INDIVIDUAL SIGNATURE AUTHORIZATION

I authorize representatives of Hawaii Prescription Care Program to sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through individual assistance programs. This signature authorization is good as long as Hawaii Prescription Care is assisting me or until I revoke such authorization.

Full Printed Name Of Individual: _____

Signature _____ Date _____

PLEASE CALL HAWAII PRESCRIPTION CARE EACH TIME YOU RECEIVE MEDICINE UNDER THE PROGRAM.

Physician/Prescriber Referral for Medications

Phone: 599-6000, 1-800-599-6441 Fax: 599-6003

PHYSICIAN/PRESCRIBER COMPLETES THE FOLLOWING:

Referral Date:	Who can answer questions about this referral?
Name of Clinic/Hospital associated with this referral:	

Individual Last Name _____ First Name _____ Social Security Number _____

PHYSICIAN/PRESCRIBER INFORMATION

Last Name:	First Name:		MI:
Specialty:	Title:	DEA#:	Exp:
State License #:	State:	Exp:	UPIN #:
Address:			
Suite/Building:	E-mail Address:		
City:	State:	Zip Code:	
Office Contact::	Phone #:	Fax #:	

MEDICATION INFORMATION:

BRAND NAME MEDICATION (Do not list generics)	DOSAGE	FREQUENCY	DIAGNOSIS

Please indicate below if you wish correspondence or medications directed to an alternative address:
Direct all Physician/Prescriber correspondence to:

Ship Medications to: _____
Prescriber's above address or other office location

_____

Prescriber's Signature: _____ Date: _____